ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: DEC. 15, 2020 Case Number: 21-71

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Rachel Liepman, DVM MS
Premise Name: Chaparral Veterinary Medical Center
Premise Address: 32100 N. Cave Creek Rd.
City: Cave Creek State: AZ Zip Code: 85331
Telephone: (480) 595-8600

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Mark Caldemeyer MD
Address: [redacted]
City: [redacted] State: [redacted] Zip Code: [redacted]
Home Telephone: [redacted] Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. PATIENT INFORMATION (1):

Name: Lightfoot / Cowboys N Stetsons

Breed/Species: Paint

Age: 3 yo Sex: Gelding Color: DUN / Tobiano

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:

Please provide the name, address and phone number for each veterinarian.

Surgeon
Christine Moyer, DVM, MS
Chaparral Veterinary Medical Center
32100 N. Cave Creek Rd.
Cave Creek, AZ 85331

E. WITNESS INFORMATION:

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Roberto Estrado
[redacted]

[redacted]

John Moody
[redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: Mark Caldwell M.D.

Date: 12/7/2020

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

To whom it may concern,
Our horse, Lightfoot, a 3 year old Paint gelding began to experience symptoms of colic midday Thursday, 5/14/2020. We live in Prescott, AZ and our local veterinarian, Bryan Nolte came out to the barn to evaluate him. He felt we should trailer him to his clinic for further treatment that evening. After several hours, he called and said he felt the colic was getting worse and we should transfer him to a facility that could provide a surgical treatment. He recommended a facility in Gilbert or Chaparral. We decided to go to Chaparral since it was the closest. Our trainer, Roberto Estrada agreed to take him. We got there around 10 p. He was evaluated by Dr. Liepman, who thought he could be treated medically initially, but felt he had a high likelihood of progressing to need surgery. They stated he was the fourth or fifth horse to need surgery that evening, and eventually went to surgery around 5 am 5/15/2020. We were told surgery went well, that he had a 720 degree colonic volvulus, but should make a full recovery. We did find out later after his death, when speaking with the owner of the clinic regarding the timing and potential cause of his death, that she had been consulted during his surgery. That is never mentioned in the medical records, so we are not sure why that consultation occurred or the significance of that consultation.

His recovery seemed fairly uneventful. He did have low grade tempatures, the cause of which was not determined. Therefore, he was kept for an extra day than planned. My wife went to visit him the day before he was discharged, and felt he was not himself as he seemed nervous and wasn't interested in grazing, which was unusual for him. She noticed his urine was darker color and was thicker and therefore seemed concentrated. She expressed concern to the Vet assistant when she brought the horse back to the barn and asked if she could speak to the doctor. Dr. Liepman was unavailable at that time, taking care of another horse. Dr. Liepman called Tuesday morning 5/19/2020 and said his temperature was down and felt he could come home late that day. She did advise he had hives all over his body, and asked if that had ever happened. He was treated with Dexamethasone. She also said they had added a stall sedative medicine (Zylkene), and that they had to decrease the dose because he had been more sedated than they like the night before.

Per the recommendation of Dr. Liepman, we made the move to bring the horse home that evening. Roberto and I picked Lightfoot up around 6-6:30pm on 5/19/2020. Roberto, our trainer, again did the hauling. Lightfoot seemed fine to me, and all his "numbers" were OK according to Dr. Liepman, but Roberto later told me he thought Lightfoot wasn't acting quite right, seemed nervous, and was pawing before loading in the trailer. About 45 minutes after leaving Chaparral, Roberto noticed some blood on the side of the trailer when looking in the rear view mirror. We stopped and found Lightfoot dead in the trailer. There was a wound dehiscence with evisceration of bowel and omentum, but the startling thing / observation was the amount of blood. The entire floor and lower sides of the trailer were covered with blood, and the blood was beginning to congeal. (please see attached photo)

I am an anesthesiologist and have seen many wound dehiscence / evisceration situations. Typically, a wound dehiscence does not lead to massive bleeding unless it

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

is the result of some major catastrophic vascular event. The ride was uneventful, neither Roberto nor I noticed any thrashing or movement of any kind in the trailer. I'm not that experienced with this, but Roberto has trailered thousands of horses. I know this is supposition, but the only thing that makes sense to me, as a physician, is that Lightfoot had some massive vascular event soon after loading into the trailer, became hypotensive from the blood loss, and went down or lay down softly without thrashing, eventually dehiscing the wound from the hemoperitoneum causing his death.

I called Chaparral immediately from the side of the road. Dr. Liepman with Dr. Moyer also on the call offered condolences. They said we could bring back any medicines for a refund. We did not know what to do with his body, so I called our local veterinarian Dr. Nolte who said we could bury him at the barn or take him to the landfill in the morning, which was not an option for us. Looking back, I don't understand why Chaparral did not ask us to bring him back to their facility for a necropsy to see what really caused his demise.

At the time, my wife and I were very upset, not thinking clearly. Lightfoot was our first horse, raised by us since a 6 month colt and Roberto as his trainer for his entire life. So we took him to the barn and the barn owner, John Moody, got out his backhoe and we buried him around 10 pm that night. I believe Mr. Moody will also be happy to attest that Lightfoot's body had a wound dehiscence / evisceration with massive bleeding in the trailer.

After discussing this with our friends and colleagues, many who are long standing horse owners, trainers, and a few veterinarians, no one has ever heard or much less seen something like this after a colic or any abdominal surgery. The owner of Chaparral, Dr. Andrea, called the next day after his death and spoke on speaker phonepwith my wife Karen, in my presence, and after offering condolences, said after an internal review, that all care was appropriate and this must have happened due to a hard fall in the trailer. When we disputed this, she became confrontational and accused my wife of only being concerned with the money.

I will note that before the end of that conversation, my wife told Dr. Andrea that we did not feel we should pay them for their services. Within a few days, she had their personal attorney Mr. Stoll ([redacted]) call and spoke to my wife. He offered $3,500 "for our loss". We found this strange and declined. We had asked for a complete record of our horse's care, and it was not forthcoming. We ultimately hired an attorney to attempt to resolve what we felt they owed, and only after repeated written requests were we provided with said record.

In summation, our horse Lightfoot died a very short time and certainly much less than 45 minutes after leaving Chaparral when we found him dead in the trailer since the blood in the trailer was already congealing. This was after a presumably successful colic surgery. He was an otherwise healthy horse who died of massive hemorrhage in a horse trailer. There was no thrashing or unusual movement in the trailer to indicate

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

any type of hard, traumatic fall to cause such bleeding. In my best opinion, as a medical professional, this horse, 4 days post operative, likely had an undiagnosed vascular injury that broke open during trailer loading/ normal jumping up into the trailer leading to the massive hemorrhage minutes later.

Unfortunately, there is no necropsy to confirm this, but again we find it unusual that Chaparral did not ask to have Lightfoot brought back for such examination. For these reasons, we ask that you consider all these facts. We understand that what we present to you may not "be comprehensive", but we only have the information Chaparral provided, and they seem unwilling to take any responsibility or consider any fault.

At the risk of speculation, we feel like this tragic incident may have been the consequence of several factors each of which warrant an investigation by your Board. Again, supposition, but it seems the combination of an in-experienced and over worked junior veterinarian, and lax post-operative care were the primary contributing factors. The fact that legal counsel's demands were necessary to secure the supposedly complete veterinary treatment record and therein was an absence of at least one known consultation with a senior veterinarian in the practice during surgery begs the questions that they may be hiding something.

We write to you today in the interest of having a qualified and objective investigation into the protocols of Chaparral in this instance so that (1) this type of unfortunate situation is not bestowed upon other animal owners who place their trust in licensed veterinarians at Chaparral or other vet clinics, and (2) we can determine how best to proceed in responding to their payment demands.

Thank you,
Sincerely,
Mark Caldemeyer M.D.

Contacts:
Mark Caldemeyer MD Karen Caldemeyer MD

January 6, 2021

In re: Case 21-71

Dear Arizona State Veterinary Medical Examining Board:

I am writing in response to the Complaintfiled by Drs. Caldemeyer in connection with the death of their 3-year-old paint gelding named 'Lightfoot.'

On the evening of May 14, 2020, 'Lightfoot' Caldemeyer presented to our clinic as a referral from his primary veterinarian (Dr. Nolte) for colic signs that were unresponsive to medical treatment. He had a history of narcolepsy of undetermined cause prior to this colic episode of which I was advised about multiple times by both the owners and Dr. Nolte.

After thorough intake evaluation of Lightfoot, including bloodwork, nasogastric intubation, transrectal palpation, abdominal ultrasonography and peritoneal fluid analysis, it was determined that Lightfoot had a large colon problem that caused him to develop severe gas distention of that portion of the intestinal tract. However, based on parameters collected at time of hospital admission, he was stable enough to hospitalize and start on supportive care including sedatives and fluid therapy. Informed consent was obtained at the time of hospitalization.

Later, Lightfoot returned to pain and Dr. Renee Andrea, DACVS was contacted while Dr. Christine Moyer, DACVS was in surgery with another patient. After re-evaluation, it was determined that Lightfoot's management could proceed medically. Repeat evaluation under light sedation including rectal examination, nasogastric intubation and abdominocentesis for peritoneal fluid analysis was undertaken, and his pain had again subsided. Objective values obtained from this assessment were improved from admission. Return to pain beyond this point in his management would prompt surgical intervention. His pain recurred on the first night of hospitalization and surgery to correct a large colon problem was recommended and elected at that time. A 720-degree large colon volvulus was discovered and corrected. The surgical procedure was routine and no intestine needed removal. No excessive bleeding or other abnormalities were present during thorough exploration of his abdomen. His body wall was closed routinely in 3 layers and a stent bandage placed over the incision for recovery. Anesthesia was routine and he recovered well.

Post-operatively, Lightfoot was closely monitored with frequent physical examinations including evaluation of the IV catheter site and surgical site for any changes. He was given perioperative antibiotics, fluid therapy and analgesics. Bloodwork was evaluated serially peri-operatively due to mild postoperative fevers and to help determine length of antibiotic therapy. Signs and clinical parameters of hemoabdomen including anemia,

hypoproteinemia, tachycardia, abdominal pain or distention were not present at any point post-operatively. He was kept in hospital for a total of 5 days and his fever resolved. The owners were routinely communicated with throughout hospitalization and informed of any changes in his condition. They were made aware that he was neutropenic on the day of discharge and that the screening gastrointestinal panel was still pending but since he was clinically well, discharge was medically appropriate. Biosecurity protocols and recheck with Dr. Nolte was recommended. At time of discharge, his incision was examined with his owner and was normal, clean and dry with no discharge or incisional edema. He was eating, drinking, urinating and defecating well and his physical exam was normal. Serial checks of packed cell volume and total protein twice daily were normal.

The owner was concerned about his post-operative lay-up period due to the horse's anxiety in a box stall. He asked about giving a calming pharmaceutical over this time. I advised that we start with a more natural calming agent (Zylkene) and if that helped, we could continue that for his lay-up period at home. This treatment was initiated in the hospital and allowed him to stay calmer while stalled. While under our observation, we titrated the daily amount given based on his overall attitude in a box stall at the clinic. He was discharged with recommendations to continue Zylkene, oral probiotics and a gastroprotectant.

Several times during his hospital stay, he was observed having episodes of narcolepsy, where he was seen abruptly falling to his knees from a standing position, consistent with reports of his pre-existing condition. He was loaded onto the trailer by the owner after reviewing discharge instructions without anticipated complications. The owners did not voice any concerns about his condition to me at discharge or before discharge. They did not mention any concern about his hydration status, his attitude or appetite at several meetings when we spoke face to face or by phone. We recommended a recheck with Dr. Nolte shortly after returning home.

Chaparral Veterinary Medical Center (CVMC) is one of the only specialty referral hospitals in the state of Arizona that is staffed by board certified specialist veterinarians 24/7 to receive, triage and manage equine emergencies. Our group of doctors is highly trained and experienced in dealing with the acute abdomen, and this case proceeded as is typical for a horse with colic and a surgical option. We elected medical management prior to surgical intervention as we would with any case based on his intake parameters and level of pain. When his pain progressed to the point that it could no longer be managed medically without compromise of the patient, surgical intervention was promptly recommended and elected.

A board-certified large animal surgeon performed the surgery (Dr. Christine Moyer, DACVS) and it proceeded routinely. The horse recovered well in the hospital under the

care of myself, a board-certified large animal internist. I am very particular about close monitoring of post-operative patients in the hospital and made the owners aware of any post-operative abnormalities discovered. The owners visited several times during his post-operative period at which time I spoke to them directly and they never expressed concern about my level of care or the condition of their horse. They were very kind and complimentary to me and were impressed with the facility and care we provided. The decision to discharge 'Lightfoot' from my care was made carefully and jointly with the owners to ensure they were comfortable managing him at home. The owners were aware that follow-up was recommended when he returned home to ensure prior abnormalities discovered in the hospital had resolved.

Of note is the fact that 'Lightfoot's' tragic death occurred after he left the care of the veterinarians and staff of CVMC. When Dr. Mark Caldemeyer called me to inform me of what had happened, he was audibly shaken. He stated that he saw blood on the tailgate and stopped on the side of the road to find the horse dead: eviscerated in a pool of blood. I explained that I was shocked and extremely sorry that this had happened. I repeatedly apologized for what had happened and we (Dr. Moyer and I on the phone call) asked him multiple times to let us know if there was anything we could do.

In response to specific statements made in the Caldemeyer's complaint, I would like to make some clarifications. First, we do not discuss with our clientele how many cases or colic cases we have seen in a single evening. Sometimes clients ask us if colic is common, how often we see these types of cases or if we have seen a lot of colics recently. Specific information regarding how many colic surgeries had happened each evening is not given out as this would violate our confidentiality agreement with our clients. Mark's statement that we had four or five horses go to colic surgery that evening is false and unfounded. Their horse was taken to surgery when it was necessary and was the second horse of the evening to need surgical intervention for an acute abdomen; not an unusual evening at our equine referral hospital. Consultation with Dr. Andrea was done internally and was not discussed with the owners. The reason Dr. Andrea was consulted (one of the owners of the practice and a board certified large animal surgeon) was that logistically, if 'Lightfoot' needed to go to surgery, another surgeon would need to take him since the surgeon on call was working on another case. I wanted to be sure she agreed that we could proceed medically and at his reassessment, it was clear that he was still stable (and in fact, had improved some since admission) and his pain subsided with mild sedation. She made herself quickly available on her night off to assist in this matter with me and was willing to perform his surgery if need be. Not only was his care in accordance with what is considered "standard of care," three board certified specialists personally evaluated him to ensure he received the *best* care possible while under our supervision.

Second, Mark states that he and the trainer were concerned about 'Lightfoot' at time of discharge. I met Mark in person to discharge the horse, and discussed his discharge paperwork in detail with him. We stood next to him and leaned down to look at his surgical incision so that Mark could see how it looked at the time of his leaving my care. The incision was clean and dry with no incisional or peri-incisional edema. Examining the incision with the owner prior to discharge is something I do routinely to ensure that if a change is noted with the incision at home (ie. edema or drainage) that we had looked at it together prior to leaving my care. Neither Dr. Caldemayers nor the trainer expressed any concerns whatsoever about 'Lightfoot' to me at that time nor after they loaded him in the trailer.

Third, the Caldemeyers claim that they have ample experience with wound dehiscence and evisceration since they are human physicians and that massive bleeding cannot happen in association with dehiscence unless there is an accompanying major vascular event. He suggests that in post-operative management, I missed a major vascular event, such as an internal hemorrhage since neither he nor the trainer recall any event during trailering that would have preceded his fall to the ground. He mentions that his trainer has a lot of experience trailering horses and that 'Lightfoot' did not fall or thrash while being trailered.

While I cannot say with certainty what happened to 'Lightfoot' on the ride home, I suspect, based upon his history and how well he appeared at discharge that evening, that he abruptly fell (perhaps had a narcoleptic episode) while in a fast-moving trailer and the weakest point in his abdomen ruptured (his healing abdominal incision). Despite the owners' claim that "the ride was uneventful; there was no thrashing or unusual movement in the trailer to indicate any type of hard, traumatic fall...etc", 'Lightfoot' fell to the ground when or shortly before he died, as he was found down and dead in the trailer, whether it was felt by the drivers or not. If a horse were to fall in a trailer after an abdominal incision, the weakest point (a healing, sutured wound) would most likely be affected most significantly. The weight of the intestinal tract pulling on the vessels branching off the aorta going to the intestinal tract and other organs would be more than enough to cause a catastrophic bleed leading to acute death. This is not easily understood by a human physician, perhaps due to the quadruped's massive size, weight and anatomy. I do not feel that the two situations (human vs equine) can be easily compared.

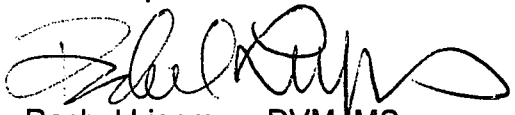
Four, Dr. Caldemeyer did not ask me what to do with 'Lightfoot's' body when speaking that day. I spoke to Dr. Nolte shortly after my phone call with Mark and told him what had happened. He stated that he would speak with them as well. I expressed my condolences for such an unexpected and tragic outcome. I was called later that evening by Karen who was also audibly traumatized by the incident and was not speaking very clearly. She told me 'Lightfoot' was being buried and that they'd spoken to Dr. Nolte.

Post-mortem exam would have been a feasible option either with return of his body to the clinic or could have been performed at the home farm by Dr. Nolte. Karen expressed on the phone with me that she wanted to speak to the practice owners and that she knew that I had done a great job caring for 'Lightfoot' she just didn't understand how this could happen. I apologized to her numerous times, ensured her that I'd have the practice owners call her and asked again if there was anything I could do to help more. I was advised that Dr. Andrea called them to discuss shortly after being informed of their request.

Fifth, the Caldemeyers provided informed consent for the care weprovided for their horse 'Lightfoot.' In the signed consent form, there is a statement on the top of page two that reads: "When animals are discharged, owner or agent assumes responsibility and risks for home care." Additionally, they agreed to pay for the care of their horse and understood how things were going financially along the way. They did not express any concern about the costs of his care. We do not know what happened that caused 'Lightfoot's' tragic loss, however what happened occurred outside of our care.

Finally, the Caldemeyers have stated that we should be investigated for multiple reasons including: care by an inexperienced, over-worked, junior veterinarian and lax post-operative care. Our team is probably the most experienced in the state at dealing with a horse with an acute abdomen, and our care was above and beyond the standard of care and was not "lax" in any way. Also I am not sure what their definition of "junior veterinarian" is, but I, nor my colleague Dr. Moyer fit that description, considering our advanced training and subsequent board certification in our respective AVMA recognized veterinary specialties as well as our years in clinical practice. Their statement that legal counsel was necessary to obtain the complete medical record is also false. We were asked for the medical record and provided it in a timely fashion at their request. Also, as mentioned above, consultation with our senior surgeon was pursued to ensure that 'Lightfoot' received the best and most efficient care possible, not because we were "hiding something."

In sum, all diagnostics and treatments throughout his hospitalization and under our close supervision met or exceeded the standard of care set forth by the American Veterinary Medical Association (see document entitled 'Principles of veterinary medical ethics of the AVMA'). We again extend our condolences to the Caldemeyer family for the unexpected loss of their beloved horse.



Rachel Liepman, DVM, MS
Diplomate of the American College of Veterinary Internal Medicine (Large Animal)

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

1740 W. ADAMS STREET, STE. 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1-PET (1738) ♦ FAX (602) 364-1039
VETBOARD.AZ.GOV

INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: AM Investigative Committee: Robert Kritsberg, DVM - Chair
Christina Tran, DVM - ***Absent***
Carolyn Ratajack
Jarrod Butler, DVM
Steven Seiler

STAFF PRESENT: Tracy A. Riendeau, CVT - Investigations
Beth Campbell, Assistant Attorney General

RE: Case: 21-71
Complainant(s): Mark Caldemeyer, MD
Respondent(s): Rachel Liepman, DVM (License: 6649)

SUMMARY:
Complaint Received at Board Office: 12/15/20
Committee Discussion: 6/8/21
Board IIR: 7/21/21

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow).

On May 14, 2020, "Lightfoot," a 3-year-old Paint gelding was presented to Dr. Liepman on referral due to signs of colic that was unresponsive to treatment. The horse was hospitalized for supportive care and possible surgery if no improvement.

The next morning, Dr. Moyer performed surgery on the horse due to returning pain. Surgery was performed and the horse recovered uneventfully. The horse remained hospitalized for monitoring and supportive care for the next several days.

On May 19, 2020, the horse was discharged. Complainant and his trainer loaded up the horse in the trailer to travel back to Prescott. During the trip home, blood was noticed on the side of the trailer; Complainant pulled over, opened up the trailer and found the horse dead with wound dehiscence and evisceration of bowel and omentum.

Complainant was noticed and appeared telephonically.
Respondent was noticed and appeared with counsel David Stoll.
The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Mark Caldemeyer, MD*
- Respondent(s) narrative/medical record: *Rachel Liepman, DVM*
- Consulting veterinarian(s) narrative/medical record: *Bryan Nolte, DVM – PAHEC*

PROPOSED 'FINDINGS of FACT':

1. On May 14, 2020, Dr. Nolte was contacted by the horse's trainer who reported the horse had symptoms of colic. Dr. Nolte visited the horse in the field and a 1500 pound dose of Banamine was administered to the horse with no improvement. The horse was eating and drinking but had not passed any stool.

2. Later that day, the horse was presented to Dr. Nolte due to no improvement. The horse had a temperature = 99.9 degrees, a heart rate = 40bpm, and a respiration rate = 16rpm; diminished borborygmi, slight gut sounds heard ventrally, decreased/quiet in all other quadrants. One fecal ball in the rectum and a moderate amount of gas was found on rectal exam. The horse was sedated with detomidine and xylazine IV; buscopan was administered IM; and a nasogastric tube was placed through the right nostril. There was a foul smell to the stomach, no reflux – electrolyte water and mineral oil was administered through the nasogastric tube; the nasogastric tube was removed. Complainant elected to hospitalize the horse after Dr. Nolte discussed their options.

3. The horse was hospitalized for IV fluid therapy and calcium gluconate. Approximately 20 liters of fluids were administered through the evening. The horse had progressive abdominal distention, decreased gut sounds and increased heart rate despite pain management. Dr. Nolte's follow up rectal suggested displaced dorsal colon – Complainant elected referral to Chaparral Veterinary Medical Center therefore Dr. Nolte called the premises to let them know the horse was on its way and the treatment he had provided; Dr. Nolte also advised the horse had narcoleptic tendencies.

4. The horse presented to Dr. Liepman on referral. The horse had a weight = 1060 pounds, a temperature = 102.1 degrees, a heart rate = 42bpm, and a respiration rate = 30rpm; BAR, slightly anxious from the trailer ride, and no signs of colic at presentation. Blood work was performed:

PCV	*38%*
Lactate	*3.4*
SSA	*3*
CBC	*Normal limits*
Chemistry	*Slight hypocalcemia (10.2)*

5. A nasogastric tube was placed; no net reflux, foul smelling sour feed and quite a bit of gas. Transrectal palpation revealed a very gas distended large colon in the pelvic inlet. Dr. Liepman was only able to get in wrist deep. Abdominocentesis – yellow; lactate – 4.0; protein – 1.2.

6. The horse was hospitalized for IV fluid therapy and lidocaine CRI. The horse was sedated and checked for reflux when he returned to pain. At that time the operating room was occupied by another patient. When the horse returned to pain, a repeat abdominocentesis and blood lactate was repeated and revealed the lactate values where returning to normal ranges. However, the horse returned to pain therefore surgical intervention was recommended and approved by Complainant.

7. According to Dr. Liepman, when the horse returned to pain, she contacted Dr. Andrea (a surgeon at the premises) since her associate, Dr. Moyer, was in surgery with another patient. Dr. Andrea offered to perform surgery on the horse if Dr. Moyer was still in surgery – however, after Dr. Andrea evaluated the horse, it was determined that he did not need surgery at that time and Dr. Andrea left.

8. On May 15, 2020, the horse again returned to pain, he was more fractious, and the blood lactate had risen again. A large gas distended colon was present and pushed caudally into the pelvic inlet. The horse was pawing and circling in the stall and appeared anxious – the horse was still bloated in the abdominal contour. Surgical explore for a suspected large colon lesion was elected.

9. Dr. Moyer examined the horse; temperature = 99.8 degrees, a heart rate = 40bpm, and a respiration rate = 20rpm. The horse was premedicated with xylazine, induced with ketamine and diazepam, intubated and maintained on isoflurane and oxygen throughout the surgery. Dr. Moyer found the cecum and large colon severely distended with gas and was decompressed with large bore needle suction. There was a 720 degree segmental volvulus of the pelvic flexure. The lesion was reduced, and a pelvic flexure enterotomy was performed. The remained of the abdomen was unremarkable – the abdomen was lavaged and closed in three layers using surgical glue to appose the skin. A stent bandage was placed prior to recovery from anesthesia which was uneventful.

10. After surgery, the horse remained on IV fluids, lidocaine, injectable antibiotics – gentamicin and procaine penicillin – and NSAID therapy. Dr. Liepman oversaw the horse's care and noted that he developed fevers post operatively which lasted until the early morning the following day (May 16, 2020). She kept in contact with Complainant to give updates Dr. Liepman reported that the horse had some post-op fevers and was groggy, but overall much more comfortable. The horse had also passed some loose manure which would be monitored. The horse would be offered some feed the next day if he was comfortable and doing well.

11. On May 16, 2020, the horse remained hospitalized on IV fluids (plasmalyte), NSAIDS, and antibiotics. Dr. Liepman advised Complainant that the horse was started back of feed and they would slowly introduce him to his hay over the next few days as he tolerates. They discussed colic prevention and feeding/management.

12. On May 17, 2020 (Sunday), the horse continued to do well; passing manure, hungry and happy. Dr. Liepman advised Complainant was slightly lymphopenic but otherwise the blood work looked good. They planned to stop the antibiotics and discharge the horse the following evening if he continued to do well. Dr. Liepman wanted to monitor the horses fluctuating temperature. Complainant came to the premises to visit with the horse; Dr. Liepman spoke with Complainant – he asked about long-term sedation and they discussed the possibilities including zylkene while in the hospital. Later that day, Dr. Liepman texted Complainant explaining that she would like the horse to stay another day beyond Monday due to a slightly elevated temperature (101.7). Complainant was happy with the plan.

13. On May 18, 2020, the horse continued hospitalization and was being administered flunixin injectable, as well as being given Assure Guard Gold. The horse had some minor abrasions on his knees from a narcoleptic episode. The injuries were cleaned with betadine and SSD was applied. Dr. Liepman called Complainant with an update – the horse had a temperature = 101.2 degrees, but was comfortable, bright and eating. She felt the horse could be discharged on Tuesday or Wednesday. They discussed feeding recommendations and Dr. Liepman advised that they had started zylkene. Complainant's wife visited the horse and took him for a walk. Dr. Liepman did not have an opportunity to speak with her. According to Complainant, his wife did not feel the horse was himself; he seemed nervous and was not interested in grazing.

14. Later, Complainant told Dr. Liepman that he planned on picking up the horse the following evening between 6 – 6:30pm if he remains stable. She recommended stall rest for the next 30 days. Technician reported that the horse had large patchy welts on his face, both sides of his neck, on his shoulders, and between his hind legs; his sheath was also swollen.

15. The next day (5/19/21), technical staff noted the horse still had hives over his body therefore he was not fed Assure Guard Gold due to it being the only change that was had. Dr. Liepman spoke with Complainant; she told him about the hives, which Complainant said the horse had not had in the past. They discussed possibilities of what caused the hives, types of feed to give the horse and zyklene administration.

16. That evening, Dr. Liepman and Dr. Moyer evaluated the horse and checked the incision, which was free from discharge and non-painful. Complainant and his trainer loaded up the horse sometime between 6 – 6:30pm. About 45 minutes after leaving the premises, the trainer noticed some blood on the side of the trailer when looking in the rear view mirror. They stopped and found the horse dead in the trailer – there was wound dehiscence with evisceration of bowel and omentum. Also there was blood that covered the entire floor and lower sides of the trailer which was beginning to congeal.

17. At 7:18pm (according to Dr. Lipeman), Complainant called to report what had transpired. Dr. Liepman and Dr. Moyer were both on the phone. Dr. Liepman stated that Complainant was audible shaken – she explained that she was shocked and extremely sorry that this had happened. Complainant also called Dr. Nolte who said the horse could be buried at the barn or he could be taken to the landfill. Complainant did not know why the veterinarians at Chaparral did not ask him to bring the horse back to their facility for a necropsy to determine a cause of death.

18. Complainant stated that the trailer ride was uneventful, neither he nor the trainer, noticed any thrashing or movement of any kind in the trailer. Complainant surmised that the horse had a cardiovascular event soon after being loaded in the trailer, became hypotensive from the blood loss, and went down, or lay down softly without thrashing, eventually dehiscing from the wound from the hemoperitoneum causing his death.

19. Dr. Moyer stated in her narrative that Complainant appeared to be in a state of shock. She thought about recommending he bring the horse back for a post-mortem exam, but it was

clear he was not in a frame of mind that would be safe for him to turn around and make a longer journey back instead of traveling a shorter distance home.

20. Dr. Moyer explained that when a horse dehisces an abdominal incision, it is not like a human. Horses have large viscera that weigh a great deal – it is likely that when the large viscera fell from the incision, there was a pull on the root of the mesentery that tore large blood vessels leading to the hemorrhage. Additionally, as animals are quadrupeds, they can walk on their organs which put undue tension of on them and can cause vessels to tear. Also, horses with hemoabdomen do not eviscerated so it is unlikely that the horse first had a vascular event that led to the evisceration. Dr. Moyer relayed that the horse did not have any hemorrhage during surgery and was monitored closely by Dr. Liepman in the post-op period. If intra-abdominal bleeding was present, it would have been easily identified with routine monitoring.

21. Dr. Moyer further stated that the horse was observed to fall to his knees during hospitalization. The horse had been previously diagnosed with narcolepsy causing him to intermittently fall asleep while standing, causing him to fall to buckle at the carpi and fall to the ground. Dr. Moyer's presumption was that this happened during the trailer ride home, and the combination of falling asleep, falling to his knees or falling down while traveling at highway speeds caused his incision to rupture and eviscerate. Complainant did not accept this explanation because they thought that he and the hauler would have noticed the horse falling to the floor during the trailer ride.

22. On May 20, 2020, Dr. Andrea spoke with Complainant and his wife about the death of the horse. Dr. Andrea relayed what she suspected happened to the horse based on the horse's history and her experience as an equine practitioner and surgeon. Complainant and his wife did not agree with her explanation and felt the horse had an undiagnosed vascular injury that broke open during trailer loading/normal jumping into the trailer leading to the massive hemorrhage minutes later.

23. A necropsy was not performed on the horse.

24. Dr. Liepman stated that Complainant made statements in his complaint that they had four or five colic surgeries the evening his horse was hospitalized. She explained that was not accurate, Complainant's horse was taken to surgery when it was necessary and was the second horse that needed surgical intervention for acute abdomen, which was not unusual for that premises.

25. Dr. Moyer reported that after the horse's death, test results revealed that the horse had Salmonella, which explained the horse's low-grade fever and leukopenia. The horse did not have any significant complications from the Salmonella and was not related to the cause of death. No additional treatment would have been recommended for the horse if he was alive, as he was eating well, drinking well, and passing normal manure following surgery.

26. Complainant stated that he had requested a copy of the horse's medical records multiple times and they were not provided. Ultimately, he had hired an attorney to attempt to resolve

what they felt they were owed, and only after repeated requests were the records provided. Dr. Andrea stated that the horse's medical records were provided in a timely fashion after the request from Complainant's lawyer.

COMMITTEE DISCUSSION:

The Committee discussed that this was an interesting case and is unlikely that what really happened will be known. However, based on the testimony and case file materials, the care the horse was provided was appropriate. Complainant believes that the horse had a vascular accident and bled internally – the Committee did not believe internal bleeding would cause the horse's abdominal incision to dehisce and internal organs to eviscerate. It appears, based on the pictures of the amount of blood, the blood splatter, and blood on the side walls of the trailer, the horse was thrashing after an acute event.

The horse did have narcolepsy and had an episode while hospitalized. If the horse fell suddenly in the trailer, the impact could have ruptured the incision, causing the evisceration which could cause the horse to panic and thrash. It is not clear why this would not be felt by the passengers hauling the trailer. The horse was not sedated therefore the fall was not a result of a sedative. There are many unknowns – the speed the trailer was traveling, if there was swaying of the trailer, or sudden braking.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the Veterinary Practice Act occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 4 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

TR

Tracy A. Riendeau, CVT
Investigative Division